CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 17, 2000

H.R. 1304
Quality Health-Care Coalition Act of 2000

As ordered reported by the House Committee on the Judiciary on March 30, 2000

SUMMARY

H.R. 1304 would exempt health care professionals from antitrust laws when they negotiate with health plans over fees and other terms of any contract under which they provide health care items or services. Professionals who form coalitions for that purpose would receive the same treatment under antitrust laws that labor organizations receive for collective bargaining activities under the National Labor Relations Act. This antitrust exemption would apply only to negotiations occurring within three years following enactment. The Congressional Budget Office (CBO) concludes that under the bill some health professionals, including doctors, dentists, and pharmacists, would join together and negotiate for higher compensation and greater flexibility in the provision of care, thereby increasing private and public expenditures for health care.

The bill would affect both federal revenues and outlays. By increasing costs to private health plans, H.R. 1304 would result in higher private health insurance premiums. In the case of employer-sponsored health plans, higher premium contributions charged to employers would be passed on to employees in the form of lower cash wages and other fringe benefits. Reductions in those taxable forms of compensation would lead to lower federal and state tax revenues. CBO estimates that federal tax revenues would fall by $145 million in 2001 and by $3.6 billion over the 2001-2010 period if H.R. 1304 were enacted.

H.R. 1304 would also raise the costs of several federal health programs. Direct spending for the Federal Employees Health Benefits Program (FEHBP), Medicaid, and the State Children's Health Insurance Program (SCHIP) would grow by an estimated $128 million in 2001 and by $2.5 billion over the 2001-2010 period. Discretionary spending by federal agencies for the FEHBP, the Tricare program of the Department of Defense, and the Indian Health Service would increase by about $150 million over ten years.

H.R. 1304 contains an intergovernmental mandate as defined by the Unfunded Mandates Reform Act (UMRA), but CBO estimates that it would impose no costs on state, local, or

tribal governments. Thus, the costs of the mandate would not exceed the threshold established in that act ($55 million in 2000, adjusted annually for inflation). However, state, local, and tribal governments would face higher expenses as purchasers of health care for their employees and as providers of health care under Medicaid. In addition, they would realize lower income tax collections as a result of lower levels of taxable income. The bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 1304 is shown in Table 1. The bill would add to discretionary spending by all federal agencies for employee health benefits and would affect mandatory spending in budget function 550 (health). It would also reduce federal revenues.

BASIS OF ESTIMATE

Under the bill, some health professionals would join together to negotiate for higher compensation and greater flexibility in the provision of care. Allowing health care professionals to bargain collectively with health plans would result in higher health care expenditures for two reasons. First, the increased market power achieved by providers who could form and maintain effective coalitions would allow them to obtain higher fees from the health plans. Second, the greater flexibility that health professionals would obtain in the provision of care would lead to greater utilization of services.

Because the bill contains a sunset provision, the full effects that the antitrust exemption could have on the health insurance market are likely not to be realized. CBO assumes that it would take five years for such legislation to have its full effect of increasing annual national expenditures on private health insurance by almost 2.6 percent in the absence of any compensating changes on the part of health plans or other entities. Although the full effects would not be realized prior to sunset (three years following enactment), the effects of the legislation would likely persist beyond the third year for several reasons: contracts negotiated during the first three years might extend beyond that period; health plans might go through an adjustment period while re-establishing utilization controls in the post-sunset period; and, since fee levels for health professionals would have been established at higher levels than would occur under current law, the market would take some time to re-adjust once the original antitrust treatment was restored. Because of the sunset provision, CBO estimates that the increase in private health insurance premiums, before compensating changes on the part of health plans and other entities, would rise to 1.5 percent in 2003 and 2004 and then gradually shrink, reaching 0.1 percent in 2010.

TABLE 1. ESTIMATE OF THE BUDGETARY EFFECTS OF H.R. 1304, THE QUALITY HEALTH-CARE ACT

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
REVENUES											
Income and Medicare Payroll Taxes (On-Budget)	0	-100	-255	-430	-505	-410	-290	-205	-145	-100	-70
Social Security Payroll Taxes (Off-Budget)	0	-45	-115	-190	-225	-180	-125	-90	-65	-45	-30
Total	0	-145	-370	-620	-730	-590	-415	-295	-210	-145	-100
DIRECT SPENDING											
FEHBP for Annuitants	0	4	9	15	16	9	5	2	1	1	*
Medicaid	0	115	250	410	455	335	245	180	130	95	70
SCHIP	0	5	12	20	23	16	10	7	5	4	3
Total, On-Budget	0	124	271	445	494	360	260	189	136	100	73
FEHBP for Postal Workers and Annuitants (Off-Budget)	0	3	7	0	0	0	0	0	0	0	0
Total, Direct Spending	0	128	278	445	494	360	260	189	136	100	73
SPENDING SUBJECT TO APPROPRIATION ACTION											
FEHBP for Active Workers	0	5	11	17	18	10	5	3	1	1	*
Indian Health Service	0	1	2	3	3	2	2	1	1	*	*
Tricare (Department of Defense)	0	5	9	14	14	9	6	4	3	2	1
Total	0	11	22	34	35	21	13	8	5	3	1

NOTES: FEHBP = Federal Employee Health Benefits. SCHIP = State Children's Health Insurance Program.
* = less than $500,000.

Health plans, firms, and workers would have incentives to adjust in a number of ways to the increase in the price of insurance that would occur under the bill. Those adjustments would result in reductions in coverage by employers and employees, changes in the types of health plans that are purchased, and reductions in the extent of coverage through increased deductibles, higher copayments, or other changes in the scope or generosity of benefits. In

the short run, plans and employers might also absorb some of the cost in the form of lower profits.

CBO assumes that such behavioral responses would offset 60 percent of the potential impact of the bill on workers' compensation other than health benefits. We estimate that the remaining 40 percent of the 2.6 percent potential increase, or about 1 percent of private health insurance costs, would be passed through to workers in the form of reduced compensation (other than health benefits). We further adjust the estimate to account for some reductions in other fringe benefits. With the sunset provision, CBO estimates that an increase of 0.6 percent in private health insurance costs would be reflected in reduced compensation.

Effect on Fees for Health Care

For the purposes of this estimate, health care professionals are separated into three categories: physicians, dentists and other health care professionals, and pharmacists. Based on projections of national health expenditures for 2000, private health insurance spending for physicians will total an estimated $128 billion, spending for dentists and other health professionals will amount to $53 billion, and spending for prescription drugs and related items will be $59 billion. The following discussion of the basis of CBO's estimate pertains to the effects that would occur if the antitrust exemption were to attain its full effects. Because of the sunset provision included in the bill, however, those potential effects would not be fully realized.

Physicians. The effect on health care costs of allowing physicians to form coalitions to bargain with health plans would depend on the gain obtained by each physician joining a coalition and the number of physicians who would join.

Based on studies of the effects of unionization on the compensation of employees, CBO estimates that, on average, doctors who join an effective coalition would secure an increase in fees averaging 15 percent. Only a fraction of all physicians would become members of such coalitions, however.

Currently 20 percent of physicians are nonsupervisory employees of a health organization and, therefore, are already eligible to form a union. (They would not be directly affected by the bill.) Of those approximately 100,000 physicians, about 40 percent are either members of unions or covered by a collective bargaining agreement. CBO expects that fraction to grow over the next several years.

Of the approximately 400,000 practicing physicians who would be newly eligible to form a coalition under the bill, CBO estimates that about one-third would join an effective coalition within five years if there were no sunset provisions included in the bill. (In addition, some physicians who did not join an effective coalition would benefit from negotiated increases in fees.) Together with the growing fraction of employee-physicians who are expected to be union members, we estimate that almost 40 percent of physicians would be union or coalition members by 2006 if there were a permanent antitrust exemption. If there were no sunset provisions in the bill, about 30 percent of all physicians would eventually join effective coalitions because of the legislation. Assuming a 15 percent average increase in fees, total physician fees would rise by about 4.5 percent. Because physicians represent about one-third of insured national health expenditures, CBO estimates that the effect of newly eligible physicians joining those coalitions under H.R. 1304 would be to increase total private health insurance expenditures by 1.6 percent in 2006 if the exemption were permanent. Because the bill includes a sunset provision, those full effects on costs would not be attained.

Dentists and Other Health Professionals. Like physicians, dentists and other health professionals who join an effective coalition under the bill would obtain higher fees from health plans. CBO assumes that those health professionals would secure the same 15 percent average increase in fees if they were able to form effective coalitions. However, CBO expects that the fraction of dentists and other health professionals who would maintain an effective coalition would be lower than the proportion of participating physicians. Also, dentists and other health professionals account for a much smaller percentage of private health expenditures than do physicians. As a result, CBO estimates that higher fees for dentists and other health professionals would increase private health expenditures by about 0.3 percent in 2006 in the absence of the sunset rules.

Pharmacists. H.R. 1304 would also make pharmacists eligible to form a coalition to negotiate with health plans over the net margins received for filling prescriptions. CBO assumes that pharmacists who could maintain an effective coalition would have the same bargaining power as other health professionals. Thus, on average, they would be able to negotiate an average increase of 15 percent in their net margins. CBO expects that about one-third of pharmacists would join an effective coalition. CBO estimates that higher fees paid to pharmacists as a result of H.R. 1304 would potentially increase private health insurance expenditures by 0.1 percent.

Effect on Health Care Utilization

Health care professionals who formed an effective coalition under the bill would also be likely to bargain with managed care plans for greater flexibility in the provision of care.

Those plans control costs to a certain extent by regulating the quantity of services performed. Not all managed care plans limit the use of services to the same extent, however. Preferred provider organizations (PPOs), for example, control costs by negotiating discounts on the prices of services and exercise very little management over the use of services. Health maintenance organizations (HMOs), in contrast, often have tighter utilization controls.

Negotiations allowed under the bill would weaken the utilization management controls used by some plans. Fee-for-service plans and PPOs would not be directly affected because they have extremely limited utilization controls. Group- and staff-model HMOs would also be unlikely to be significantly affected because the physician groups that work in those types of HMOs have a long history of less costly practice styles, exemplified by lower rates of hospitalization. Also, physicians who are employees of HMOs can already unionize under current law so any behavior they might undertake to increase utilization would not be a direct result of H.R. 1304.

In contrast, other forms of HMOs and point-of-service plans tend to be staffed by independently practicing doctors who are less integrated into the organization. Those plans have brought about utilization savings through various forms of financial incentives and administrative requirements. Such control mechanisms could be partly dismantled as the result of collective negotiations by the physicians that staff such network plans. For those plans, utilization management now yields about a 5 percent savings compared to indemnity insurance. CBO estimates that 50 percent of the utilization savings associated with coalition physicians who contract with those managed care plans would be lost as a result of the bill. This increase in utilization by coalition physicians would raise private health expenditures by 0.3 percent if the antitrust exemption were permanent.

While CBO believes that professionals who form coalitions would gain the most flexibility under this bill, the utilization effect might not be limited to health professionals who are members of a coalition. If professionals in coalitions changed the way they practice medicine, that would affect conventions of medical practice more generally. That is, the changes in the way those professionals practice their trade could spill over to the rest of the physician population. The presence of this effect is based on evidence that physicians usually adhere to the norms of practice established by their peers. CBO expects that such changes in professional practice would only increase utilization by about one-fifth of the increase in utilization that would occur in managed care plans whose utilization controls would be weakened through negotiation. This spillover effect would potentially raise private health expenditures covered by insurance by an additional 0.3 percent.

Effect on Federal Revenues and Direct Spending

H.R. 1304 would reduce federal revenues and increase direct spending (see Table 1). By increasing premiums for employer-sponsored health benefits, it would substitute nontaxable employer-paid premiums for taxable wages and would therefore decrease federal income and payroll tax revenues. CBO estimates that the bill would reduce federal tax revenues by $145 million in 2001 and by $3.6 billion over the 2001-2010 period. Social Security tax revenues, which are off-budget, account for about 30 percent of those totals.

The bill contains a provision maintaining antitrust liability for coalitions of health professionals in negotiations involving services furnished to beneficiaries of certain federal health benefit programs, including Medicare, Medicaid, the State Children's Health Insurance Programs, the Department of Defense's program to insure private health care delivered to members of the uniformed services and their dependents (Tricare), veterans' health services, the Federal Employees Health Benefits Program, and the Indian Health Service. The provision aims to insulate federal programs from any increased costs resulting from health professional collective bargaining, but CBO believes that the provision would be only partly successful.

Negotiations between health professionals and health plans that would be sanctioned by the bill would likely lead to increased compensation for services and a relaxation of some of managed care's controls over the use of those services. Health plans contracting to provide services to federal programs would not be able to separate these effects for federal beneficiaries completely. Higher compensation rates would increase the market price for professional services, and plans serving federal programs might have to increase their payment for services to assure an adequate supply to federal enrollees. Reducing managed care plans' controls over services would raise community standards for how intensively certain services are used, and plans serving a federally-sponsored population would likely need to provide comparable treatment.

The degree to which plans currently distinguish between federal and nonfederal enrollment groups would also affect the degree to which the bill's language aimed at excluding federal programs would limit federal costs. Industry practice generally distinguishes Medicare and Medicaid enrollees, but other federal groups, such as FEHBP and Tricare, may be grouped under the same contract that covers services provided to employees of private firms. It is likely that the clause aimed at excluding federal programs would ultimately be subject to litigation, because plans and providers negotiating a contract that covers services provided to employees of private firms would seek to include or exclude federal enrollment in the covered population, depending on which they feel is to their advantage. Thus, how that clause would ultimately be interpreted or applied is very uncertain.

CBO expects that, because managed care penetration in federal health programs is lower than in the private sector, the bill would have a commensurately lower effect on the costs of federal programs than on costs to the private sector. The provision to retain the antitrust sanctions for collective bargaining over services to federal beneficiaries would further reduce, but not eliminate, the effect of the bill on spending for federal health programs. On the other hand, behavioral responses for federal programs would not offset as much of the potential impact of the bill as they would in the private sector.

CBO estimates that H.R. 1304 would not have a significant effect on spending by Medicare because Medicare's administered pricing systems insulate the program from pricing changes in the private sector. However, the bill would increase direct spending by FEHBP (for annuitants), Medicaid, and SCHIP by an estimated $124 million in 2001 and by $2.5 billion over the 2001-2010 period. In the years of the projected maximum impact (2003 and 2004), the bill would increase spending by FEHBP, Medicaid, and SCHIP by 0.3 percent. In addition, CBO estimates that spending by the Postal Service for FEHBP coverage of postal workers and annuitants would increase by $3 million in 2001 and $7 million in 2002. By 2003, however, CBO anticipates that the service would increase postal rates and offset those costs. Costs to the Postal Service are classified as off-budget and would not be subject to pay-as-you-go procedures.

Assuming appropriation of the necessary amounts, CBO estimates the legislation would increase discretionary spending by federal agencies for the FEHBP for active workers by $5 million in 2001 and $71 million over 10 years.

CBO expects the proposal would also increase spending by the Indian Health Service and Tricare by about $80 million over ten years. The effect on spending by other federal health programs would be negligible.

PAY-AS-YOU-GO CONSIDERATIONS

Because the bill would affect federal revenues and direct spending, pay-as-you-go procedures would apply. The direct spending and revenue effects are shown in Table 2. For pay-as-you-go purposes, only the effects in the current year, the budget year, and the succeeding four years are counted.

TABLE 2. ESTIMATED PAY-AS-YOU GO EFFECTS OF H.R. 1304

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in receipts	0	-100	-255	-430	-505	-410	-290	-205	-145	-100	-70
Changes in outlays	0	124	271	445	494	360	260	189	136	100	73

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 1304 contains an intergovernmental mandate as defined by UMRA, but CBO estimates that the mandate would impose no costs on state, local, or tribal governments. By exempting health care professionals from state, as well as federal, antitrust laws, the bill would preempt state law, and therefore would be a mandate as defined by UMRA. However, the bill would not require states to take action as regulators in order to comply with the new exemption and in some cases might reduce their oversight responsibilities.

With certain health care professionals exempted from antitrust laws, state, local, and tribal governments would experience an increase in premiums for health insurance for their employees and would also see an increase in Medicaid and SCHIP costs. Those governments, like private entities, could take a number of actions to adjust to the increased premiums for their employees: reduce or change coverage options, require higher copayments, or increase deductibles. Over time, any remaining increase in costs would be passed through to workers in the form of reduced compensation (other than health benefits).

The bill would maintain antitrust liability for health professionals who provide services for federal health benefit programs, including Medicaid and SCHIP. However, those programs would not be completely shielded from the market changes precipitated by the bill. Consequently, CBO estimates that state expenditures for Medicaid and SCHIP would increase by about $90 million in 2001 and by about $1.2 billion over the 2001-2005 period.

Most states that tax income use the federal measure of adjusted gross income as the basis of their tax calculations. Consequently, the effect of substituting non-taxable income for taxable income for federal income tax purposes would have the effect of decreasing state income tax collections as well.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE

On March 15, 2000, CBO provided an estimate of H.R. 1304, as introduced. The estimated costs of the reported bill are lower because they reflect two modifications in the bill. The first modification limits the antitrust exemption to a period of three years. The second excludes federal programs from the antitrust exemption.

This estimate also includes spending subject to appropriation for Tricare and the Indian Health Service. (CBO had not completed those analyses for the estimate of the introduced version of the bill.) Finally, this estimate displays separately the off-budget component of the change in FEHBP spending (for the Postal Service).

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